

11987 CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY Howard Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterloo				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterloo			
c. LENGTH OF STAY IN TB 3 yrs.				d. STREET ADDRESS Rt. 1 Box 262			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ceder Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ADAMS Last ADAMS				4. DATE OF DEATH Month NOV. Day 3, Year 1957			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1891	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 6 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Ceder Creek N. C.			
11. BIRTHPLACE (State or foreign country) Ceder Creek N. C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Promise Adams				14. MOTHER'S MAIDEN NAME Eliza ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Bessie Adams Rt. 1, Box 262			
17. INFORMANT Bessie Adams				Address Rt. 1, Box 262			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive - Cardio Vascular Disease 443X DUE TO Acute Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - 6 mos. (c) - 1 month.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 7, 1957 to Nov. 3, 1957 , that I last saw the deceased alive on Nov. 3, 1957 , and that death occurred at 10 - M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Shank & Shiley				ADDRESS (Street, city or town, state) Savage, Md.			
PHYSICIAN'S NAME (Type) Frank E. Shiley				DATE SIGNED 11/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Ceder Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Miss Kathie R. Williams				ADDRESS 322 N. Schomberg St.			
24a. REC'D BY REGISTRAR DATE 11/7/57				24b. REGISTRAR'S SIGNATURE E. Bird Williams			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 21/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11997

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Howard b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b XO Elkridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HAMMOND COLLINS		4. DATE OF DEATH Month Day Year November 12, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1904
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Lee Collins		14. MOTHER'S MAIDEN NAME Ida J. Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Thomas L. Collins, Elkridge, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Alcoholism 581.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty Infiltration of Liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.1		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11/12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-57	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Elkridge, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS	
REC'D BY REGISTRAR NOV 14 1957		REGISTRAR'S SIGNATURE E. Bird Williams	

NOV 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11989 CERTIFICATE OF DEATH

11998

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland				c. LENGTH OF STAY IN 1b X2 Glenelg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle E Last DAY				4. DATE OF DEATH Month Nov. Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-26-1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? Unknown				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Carroll Mullinix, Glenelg, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c) 331X				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CLARKSVILLE MD.				20g. (County) CLARKSVILLE MD.			
20h. (State) CLARKSVILLE MD.				20i. (City or town) CLARKSVILLE MD.			
21. I certify that I attended the deceased from 4/1 , 19 57 , to 11/15 , 19 57 , that I last saw the deceased alive on 11/14 , 19 57 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.				22. ADDRESS (Street, city or town, state) CLARKSVILLE MD.			
23. ACTUAL SIGNATURE Charles S. Whitaker				24. DATE SIGNED 11/16/57			
25. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.				26. DATE NOV 18 1957			
27a. BURIAL, CREMATION, REMOVAL (Specify) Burial				27b. DATE THEREOF 11-18-57		27c. NAME OF CEMETERY OR CREMATORY Mt. View	
27d. LOCATION (City, town, or county) Alpha Md				27e. (State) Alpha Md			
28. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				29. REC'D BY REGISTRAR NOV 18 1957			
30. REGISTRAR'S SIGNATURE Charles Whitaker				31. DATE NOV 18 1957			

CERTIFICATE OF DEATH

FILE NO.

NOV 18 1957

BUREAU V. S.

NOV 18 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11990

Items 13, 14, Film G222 11-12-57 et

CERTIFICATE OF DEATH

11999

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b Baltimore (22) 0353.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 8244 Northview Rd	
3. NAME OF DECEASED (Type or print) First John Middle --- Last Litzenburg		4. DATE OF DEATH Month November Day 5 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 8 Days 2 Hours 6 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY B&O employee	
11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME Hiram L. Litzenburg		14. MOTHER'S MAIDEN NAME Georgianna Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. & Mrs. Joseph P. Jacob		Address 8244 Northview Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5-6 mo 6-8 mo years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis due to cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 27 th 1957 to Nov. 5 1957 , that I last saw the deceased alive on Nov. 5 1957 , and that death occurred at 6 20 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving J. Taylor M.D.		ADDRESS (Street, city or town, state) Taylor Manor Hospital	
PHYSICIAN'S NAME (Type)		DATE SIGNED 11/5/57	
22a. BURIAL-CREMATATION, REMOVAL (Specify) 11-7-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stein Funeral Home		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 6 1957		24b. REGISTRAR'S SIGNATURE J. Loughran	

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH - ATTORNEY GENERAL

Name of Deceased		Date of Death	
John		Nov. 2, 1957	
Age		Date of Birth	
60		Nov. 2, 1897	
Sex		Place of Birth	
Male		Massachusetts	
Marital Status		Cause of Death	
Married		Chronic degenerative diseases	
Occupation		Immediate Cause of Death	
Retired		Ischemic heart disease	
Usual Residence		Underlying Cause of Death	
Boston, Mass.		Chronic degenerative diseases	
Place of Death		Date of Burial	
Boston, Mass.		Nov. 2, 1957	
Burial Place		Signature of Physician	
Cemetery		[Signature]	
Burial Place		Signature of Registrar	
Cemetery		[Signature]	

RECEIVED
 NOV 6 1957
 BUREAU V. B.

11991

CERTIFICATE OF DEATH

12000

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
c. LENGTH OF STAY IN 1b <u>6 mo</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ramsey Drive - Howard Heights</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>Ramsey Drive</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER-JOSEPH-MELZER</u>		4. DATE OF DEATH <u>Nov. 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 22 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Car-Lowrey Sales</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank C. Melzer</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Reiber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-106159</u>	
17. INFORMANT <u>Pearl M. Heidicker</u>		Address <u>Ramsey Drive St. E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 15 1953</u> to <u>Nov. 15 1957</u> , that I last saw the deceased alive on <u>Nov. 1 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>J. Nelson McKay</u>		M.D. <u>6014 Edmondson Ave Balto 28 MD 11-16-57</u>	
PHYSICIAN'S NAME (Type) <u>J. Nelson McKay, M.D.</u>		<u>6014 Edmondson Ave. Balto. 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 19 1957</u>	<u>Loudon Park</u>	<u>Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>John D. Penfel</u>		<u>5311 Edmondson Ave</u>	<u>NOV 18 1957</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 18 1957

RECEIVED

11992

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG223 11-27-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COOKSVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 COOKSVILLE	
		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First ERNEST Middle SYLVESTER Last MILES		4. DATE OF DEATH Month November Day 15 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1895 62 yrs.
9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver Scott Miles		14. MOTHER'S MAIDEN NAME DEBORAH LOCKMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 2-9-28-8339	
17. INFORMANT Katie Miles, Cooksville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57	
22c. NAME OF CEMETERY OR CREMATORY Bushy Park		22d. LOCATION (City, town, or county) (State) Cooksville, Howard, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight		ADDRESS Cooksville, Md.	
24a. REC'D BY REGISTRAR NOV 21 1957		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

NOV

RECEIVED

11993

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 5 months			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS Marlin House Hotel			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Estelle Middle Robinson Last				4. DATE OF DEATH Month November Day 18 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 20, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 9 Days 29		IF UNDER 24 HRS. Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, S. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Robinson				14. MOTHER'S MAIDEN NAME Selena Glanze			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Arthur U. Hooper, 100 St. Paul St., 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, severe (c) unknown				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis; decubitus ulcers; varicose ulcers				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1957 Hour 8 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 20, 1957 to Nov 18, 1957 , that I last saw the deceased alive on Nov 18, 1957 , and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Stephen Lee Magness M.D. Taylor Manor Hospital, 11/18/57							
PHYSICIAN'S NAME (Type) Stephen Lee Magness; M.D. Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin 17, Md				24a. REC'D BY REGISTRAR NOV 20 1957		24b. REGISTRAR'S SIGNATURE E. Dougherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. ARMY

NOV 1944

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12003

11994

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Y. Ct.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 218 St. Mary's Road	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Albert Middle Rosenthal Last Rosenthal			4. DATE OF DEATH Month November Day 30 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1893	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Retail		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE - Md		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME FREDERICK W. ROSENTHAL			14. MOTHER'S MAIDEN NAME IDEL		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 217-9-0084		16. SOCIAL SECURITY NO. 217-9-0084		17. INFORMANT MRS. KATHRYN M. ROSENTHAL	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial failure DUE TO (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 hrs. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) behavioral reaction Chronic brain syndrome with senile brain disease with			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 23 , 1957, to Nov 30 , 1957, that I last saw the deceased alive on Nov 30 , 1957, and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11/30/57	
ACTUAL SIGNATURE Stephen Lee Magness	M.D. Taylor Manor Hospital, Ellicott City Md
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hospital, Ellicott City Md	

22a. BURIAL, CREMATION, REMOVAL (Specify) 12-4-57	22b. DATE THEREOF 12-4-57	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem	22d. LOCATION (City, town, or county) (State) Balt Md
23. FUNERAL DIRECTOR'S SIGNATURE Lemuel J. Luck		24a. REC'D BY REGISTRAR DEC 1 1957	24b. REGISTRAR'S SIGNATURE J. C. Laughery

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11995

CERTIFICATE OF DEATH

Reg. Dist. No.

12004

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenelg</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tridelphia Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> First <u>ELIZABETH</u> Middle <u>SELBY</u> Last				4. DATE OF DEATH <u>Nov.</u> Month <u>8</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Months <u>8</u> Days <u>19</u> Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Jonathan Musgrove</u>				14. MOTHER'S MAIDEN NAME <u>Susan Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William O. Selby</u> Address <u>Glenelg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO (b) <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July, 1940</u> , to <u>Nov. 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>57</u> , and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED <u>11/8/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>11/11/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>				22d. LOCATION (City, town, or county) (State) <u>Alpha Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>			
ADDRESS <u>Ellicott City, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Maria Whitaker</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 12 1957

RECEIVED

11996

CERTIFICATE OF DEATH

12005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 10 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle Engene Last Selby				4. DATE OF DEATH Month Nov. Day 23 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1882	
9. AGE (In years (say birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman retired				10b. KIND OF BUSINESS OR INDUSTRY Balto. Trans.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Franklin E. Selby				14. MOTHER'S MAIDEN NAME Ida Ann Blacksten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-09-3851		17. INFORMANT Mrs. Agnes Dorsey, Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Coronary Thrombosis, 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Thrombosis, generalized DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 186 to Nov 1957							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1956 , 19 Nov , 19 Nov , that I last saw the deceased alive on 23 Nov , 19 57 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Apexville, Md DATE SIGNED 23 Nov 57 ACTUAL SIGNATURE Howard E. Hall M.D. PHYSICIAN'S NAME (Type) HOWARD E. HALL							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-26-1957		22c. NAME OF CEMETERY Pipe Creek		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR DATE NOV 26 '57		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. E.

NOV 26 1957

RECEIVED